Alberta Strategic Clinical Networks – Progress Report

Canadian Critical Care Forum
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Critical Care Strategic Clinical Network
Non-sustainable healthcare cost increases in Canada:
Alberta is above average

1975 to 2010
- Expenditure increases = 3.5 fold
- Population increases = 1.5 fold

23.4M people

34.2 M people
In 1996, Alberta spent less than the average of other Provinces, with spending (in current dollars) diverging over the period.

Provincial Government Current Health Care Expenditure
per Unadjusted Capita, by Jurisdiction, 1996 to 2008

Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 – 2008 (Ottawa, Ont.: CIHI, 2008).
In 2008 Alberta had the second highest per capita spending of all Canadian Provinces

Provincial Government Current Health Care Expenditure\(^1\)
per Unadjusted Capita, by Jurisdiction, 2008

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Expenditure per Unadjusted Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland</td>
<td>3,944</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>3,283</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>3,522</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>3,460</td>
</tr>
<tr>
<td>Quebec</td>
<td>3,022</td>
</tr>
<tr>
<td>Ontario</td>
<td>3,274</td>
</tr>
<tr>
<td>Manitoba</td>
<td>3,624</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>3,572</td>
</tr>
<tr>
<td>Alberta</td>
<td>3,741</td>
</tr>
<tr>
<td>British Columbia</td>
<td>3,347</td>
</tr>
</tbody>
</table>

\(^1\) Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 – 2008 (Ottawa, Ont.: CIHI, 2008).
Alberta’s actual waits are longer in recent years

*Actual versus Reasonable Waits Between Appointment with Specialist & Treatment*¹
for Canada and Alberta, 1994 to 2009

¹ Source: The Fraser Institute's national waiting list surveys, 1995-2009.
In Alberta the Health Adjusted Life Expectancy (HALE) at birth is lower than the average for all of Canada

Health Adjusted Life Expectancy (HALE) at Birth

for Canada and Alberta, by Gender, for 2001

![Bar chart showing HALE at birth for Alberta and Canada by gender.](chart)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Alberta</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>67.6</td>
<td>68.3</td>
</tr>
<tr>
<td>Female</td>
<td>69.7</td>
<td>70.8</td>
</tr>
</tbody>
</table>

Source: Statistics Canada. Table 102-0121 - Health-adjusted life expectancy, at birth, by sex, for all income groups, Canada and provinces, 2001, CANSIM.

* Excludes the territories.
Compared to other Provinces

- Not less expensive (highest per capita, higher service intensity & higher unit costs)
- Not more accessible (maybe less)
- Not the country’s best quality for most outcomes (with clear exceptions)
- Not the longest, or health-adjusted, length of life
Getting to There From Here

• So, if we wanted to become the highest-performing health care system in Canada, what would we have to do?
• What are the key characteristics of high-performing health systems?
Top 20 Characteristics of ‘High-performing Health Systems’

• Three international conferences co-sponsored with IHE 2010/11
  • Six days, mixed Alberta audiences of 100-150 stakeholders
  • International experts from high-performing health systems
  • Synthesis of presentations for key characteristics of high-performing health systems
✓ ‘Top down’ meets ‘bottom up’ in all ways (structures, programs, goals).
What are Strategic Clinical Networks (SCNs)?

• Broad mandate:
  – Specific populations: seniors, women's health, children’s
  – Diseases with high impact: cardiovascular disease & stroke
  – High disease burden/impact: diabetes, obesity & nutrition

• Scope encompasses entire continuum of care
  – From population health & prevention to primary care to acute care to chronic disease management to palliation

• Activities better aligned with AH & AHS priority-setting integrated with and into organizational decision-making

• Resourced and supported to achieve improved clinical outcomes
How will the Provincial Clinical Mandate be Accomplished?

• Strategic Clinical Networks
• Clinically-led change
• Performance measurement, research & best evidence drive practice
• Clinical care pathways
• Clinical variance management & peer review
Clinical Networks: Our Central Goals

• Achieve the best outcomes
• Practice the highest quality of clinical care
• Seek the greatest value from resources used
• Engage clinicians in all aspects of this work
Why Clinical Networks?

• Early and positive experience with clinical networks in AHS (2009 to present)
• The need to connect top-down & bottom-up
• Strategy for clinical engagement
• Success elsewhere (Scotland, UK, Australia, OCCN)
Why Clinical Networks?

- Networks are positive ways for all partners along a broad continuum to be involved in planning & improving care & service delivery.
- Networks have proven to be an effective mechanism to ensure collaboration, joint decision-making and shared learning.
- Networks are a proven model to promote the use/uptake of clinical experience, knowledge and research to reduce clinical variation & improve care.
Injury Hospitalization - 2010/11

Age-Standardized Rate (per 100,000)

Source = CIHI Health Indicators

South Zone 825
Calgary Zone 557
Central Zone 875
Edmonton Zone 627
North Zone 1048
Best Large RHA/Zone (Central LHIN, ONT) 306

Injury Hospitalization - 2010/11
5-Day In-Hospital Mortality Following Major Surgery - 2010/11

Source = CIHI CHRP
### Acute Myocardial Infarction Readmission - 2008/09-2010/11

<table>
<thead>
<tr>
<th>Zone</th>
<th>Risk-Adjusted Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Zone</td>
<td>3.4</td>
</tr>
<tr>
<td>Calgary Zone</td>
<td>3.2</td>
</tr>
<tr>
<td>Central Zone</td>
<td>3.8</td>
</tr>
<tr>
<td>Edmonton Zone</td>
<td>2.1</td>
</tr>
<tr>
<td>North Zone</td>
<td>4.1</td>
</tr>
<tr>
<td>Best Large RHA/Zone</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Source = CIHI Health Indicators
30-Day In-Hospital Mortality Following Stroke - 2010/11

Source = CIHI CHRP
What are Strategic Clinical Networks (SCNs)?

- Collaborative clinical teams with a provincial strategic mandate
- Led by clinicians, driven by clinical needs, based on best evidence
- Comprised of an all-inclusive membership, with core members & clinical leadership
What are Strategic Clinical Networks (SCNs)?

- Maximum 25 core members, with 50% practising clinicians
  - Front-line physicians & clinicians (including primary & specialty care and community-based providers)
  - Zone/ clinical operations/ support service leaders
  - Content experts
  - Public/patients
  - Researchers
  - Alberta Health & other external partners
CORE = ‘top to bottom’ alignment in setting priorities to balance needs and perspectives
NOTE: SCNs are **NOT just AHS alone!!**

.....intended to include many other groups: Patients, public, industry, etc
Planned Support and Resources for SCNs

• **Each SCN- Dedicated Business Intelligence Unit**
  – Project management, clinical analytics, case costing, quality improvement, pathway development, patient safety, knowledge management, health technology assessment

• **Embedded research capability and expertise**

• **Education & skills development for leaders**

• **Funding including:**
  – Seed money for innovation, initiatives, and research
  – Remuneration of core members
  – Opportunities to retain savings that are realized
SCNs – January 2015

2012 - 2016 (under consideration)

1. Diabetes, Obesity and Nutrition - SCN
2. Seniors Health - SCN
3. Bone & Joint Health - SCN
4. Cardiovascular Health and Stroke - SCN
5. Cancer - SCN
6. Addiction & Mental Health - SCN
7. Emergency - SCN
8. Critical Care - SCN
9. Surgery – SCN
10. Respiratory Health – SCN
11. Maternal, Newborn, Child & Youth
13. Primary Health Care – Q 1 2016
15. Gastrointestinal
16. Neurosciences, Vision, ENT
SCNs Use a Common Quality Definition and measure one or more of six dimensions to improve.
Broad System Value Created

- **PRIORITY SETTING MECHANISMS** – utilized to set priorities
- **FORMAL BUSINESS CASE DEVELOPMENT**
- **TEST CASE for REASSESSMENT METHODOLOGY** – 1st in Canada
- **TEMPLATES TO DETERMINE VALUE FOR MONEY / BENEFITS REALIZATION METHODOLOGY** with **MEASUREMENT**
- **MATURITY ASSESSMENT & EVALUATION METHODOLOGY**
- **ATTRACTION OF NEW $$ TO AHS THROUGH PRIHS, CRIO, SPOR GRANT(S)**
- **NOVEL ENGAGEMENT METHODS** – i.e., PATIENT ENGAGEMENT RESEARCHERS
SCN Projects, Priorities & Performance
Snapshot of Existing SCN Projects

Developed in 2012-15 and in Various Stages of Implementation Now

CVS
- Vascular Risk Reduction C-CHANGE**
- Stroke Action Plan

DON
- Insulin Pump criteria**
- Enhancing recovery after surgery**

Seniors'
- appropriate use of antipsychotics**
- Elder Friendly Care**

BJ
- Fragility & Stability - Hip Fracture Rx and Prevention
- Hip & Knee 5 year Plan

Cancer
- Lung Cancer
- EMPATHY

AMH
- Depression Pathway
- Safe Surgery Checklist**

Surgery
- aCATS**
- NSQIP

Emergency
- ED Content

Critical Care
- OPPACA
- iNO

Underway & achieving results
Completed

www.albertahealthservices.ca
Project Objective

- Establish the appropriate clinical use of Inhaled Nitric Oxide (iNO) and its main alternative, Inhaled Flolan
- Develop, validate, test and implement Standards of Practice for the use of inhaled pulmonary vasodilators on adult and pediatric critical care units across Alberta.
Business Benefit and Outcomes

• Develop the best-practice knowledge regarding the cost-effectiveness and clinical appropriateness with the use of iNO and inhaled Flolan.

• Provide registered respiratory therapists, physicians, nurses (and other health care professionals) with standardized evidenced-based best-practice standards of practice to facilitate safe, efficient, and effective management and care of patients requiring inhaled pulmonary vasodilators
Business Benefit and Outcomes

- Eliminate human, equipment, and dollar cost inefficiencies (waste).

- Direct cost savings, with reduction in adult iNO usage, is estimated at least $150,000 by fiscal end 2015 for re-investment back to the Edmonton and Calgary Zone based on financial projections provided by FAPs.
## Standards of Practice

<table>
<thead>
<tr>
<th>ADULT</th>
<th>PEDIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaled Nitric Oxide Standard of Practice</td>
<td>Pediatric Non-Cardiac Inhaled Nitric Oxide Standard of Practice</td>
</tr>
<tr>
<td>Inhaled Flolan Standard of Practice</td>
<td>Pediatric Cardiac Inhaled Nitric Oxide Standard of Practice</td>
</tr>
</tbody>
</table>

- All Standards are comprised of initiation and weaning algorithms for ease of use clinically at bedside

- Initiation and weaning order sets created to guide use of the algorithms by clinicians at the bedside
## Adult Proof of Concept and Pilot

<table>
<thead>
<tr>
<th>Proof of Concept (Edmonton)</th>
<th>Pilot (Calgary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UAH GSICU, RAH ICU, MAHI CVICU</td>
<td>FMC CVICU, FMC ICU, PLC ICU</td>
</tr>
<tr>
<td>19 patients treated with inhaled pulmonary vasodilators</td>
<td>20 patients treated with inhaled pulmonary vasodilators</td>
</tr>
<tr>
<td>• 16 inhaled Flolan</td>
<td>• 1 iNO – spontaneously breathing</td>
</tr>
<tr>
<td>• 4 iNO and inhaled Flolan</td>
<td>• 16 inhaled Flolan</td>
</tr>
<tr>
<td>• 3 only iNO</td>
<td>• 3 both iNO and inhaled Flolan</td>
</tr>
</tbody>
</table>
Financial Analytics

Q2 Net Savings = $39,548.59
Q3 Net Savings = $60,276.05
Q1 Net Savings = $38,325.69
Q4 TBD

Q1 Savings related to reduction in iNO use = $77,250.00
Total cost of inhaled Flolan = $38,924.31

Q1+Q2 + Q3 = $138,150.33

Six adult units involved in the iNO Project:
UAH GSICU, RAH ICU, MAHI CVICU, FMC ICU, FMC CVICU, PLC ICU

Q3 Savings related to reduction in iNO use = $88,000
Total cost of inhaled Flolan = $27,723.95
Early Quality Improvements – SCN Projects

Appropriate Use of Antipsychotics

- 11 Early Adopter sites with High Inappropriate Use
  - Sites reduced use from 38% to 20%,
  - 657 beds impacted, 35% of clients removed from Medication
  - Currently spreading to 14,000 LTC beds by 15/16

Safe Surgery Checklist

- 59 Surgical Sites in Alberta all participating
  - Follow WHO standard – brief, timeout, debrief
  - 2012/13 observed compliance = 43%,
  - March 2014 observed compliance = 96%
  - Podcast training for patients, students & clinicians

Enhanced Recovery after Surgery

- 2 early adopter sites – LOS reductions from 14 days to 5 days, mean is 2.64 days.
  - 50% Reductions in complications
  - 6 sites implementing in 14/15
  - PRIHS scale & Spread in 15/16
AUA Project resources were shared with all 170 LTC sites in Alberta in 2014/15. Antipsychotic use continues to decline.
EARLY QUALITY IMPROVEMENTS – SCN Projects

**Appropriate Use of Antipsychotics**
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Smarter Surgical Care: Enhanced Recovery After Surgery (ERAS)

- Evidence-based clinical pathways
- Data driven quality improvement
- Local site implementation and change management

International network of leadership from Eras® Society
ERAS care story (to Dec 31, 2014)

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Coeff(^a)</th>
<th>Magnitude (^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS Primary</td>
<td>0.80*</td>
<td>-2.0 days</td>
</tr>
<tr>
<td>Complications (primary)</td>
<td>0.65</td>
<td>-19.9%</td>
</tr>
<tr>
<td>Prevented readmissions</td>
<td>0.44*</td>
<td>-9.5%</td>
</tr>
<tr>
<td>LOS for those ERAS patients admitted</td>
<td>0.62</td>
<td>-4.5 days</td>
</tr>
</tbody>
</table>

Focused on magnitude and direction compared to pre-ERAS baseline

- Well enough to go home earlier from hospital (possibly due to less complications post op)
- Less risk of being readmitted to hospital within 30 days (possibly due to less complications post discharge)
- If readmitted, could be discharged earlier (complications when experienced may be less severe)

\(^{a}\) Coefficients from adjusted multivariate models.
\(^{b}\) Calculated using the coefficients from adjusted multivariate models.

Source: IHE, April 2015
## ERAS cost impact (to Dec 31, 2014)

$2.1 to $4.6 million in net costs saved with 690 ERAS patients (PLC & GNH)
$3.1k to $6.6k with 3.5 bed days saved for each ERAS patient

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Magnitude</th>
<th>Cost Impact ($ per inpatient day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low= $1,114</td>
</tr>
<tr>
<td>LOS Primary (n=690)</td>
<td>-1,380 days (2.0 * 690)</td>
<td>$1,537,320</td>
</tr>
<tr>
<td></td>
<td>-66 admissions (9.5%*690)</td>
<td>$868,548</td>
</tr>
<tr>
<td></td>
<td>-780 days in hosp (66*12c)</td>
<td>$306,350</td>
</tr>
<tr>
<td>Prevented Readmissions (n=690)</td>
<td></td>
<td>$868,548</td>
</tr>
<tr>
<td>LOS for those ERAS patients re-admitted</td>
<td></td>
<td>$306,350</td>
</tr>
<tr>
<td>(n=61)</td>
<td></td>
<td>$1,537,320</td>
</tr>
</tbody>
</table>

### Total Estimated Savings

- $2,712,218
- $5,127,407

### Total Cumulative Intervention Cost of ERAS

(PLC and GNH ending Dec 31, 2014)

- $546,492

### Net Cost Savings

- $2,165,726
- $4,580,915

### Break even point – surgery #

- 174
- 82

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**Source:** IHE, April 2015
EARLY QUALITY IMPROVEMENTS – SCN Projects

Vascular Risk Reduction
- C-Change Guideline Harmonization – 1000 FP’s trained (TOP)
- Risk Reduction Clinics established
- 78 Pharmacies engaged
- 1 Major Worksite

Fragility & Stability
- Acutecare Fracture Care pathway implemented
- 75% of patients to OR within 48 hours
- Post Acute Pathway - under development
- Catch a Break program implemented with Health Link Alberta

E-Referral
- Defined e-referral workflow across continuum
- Launch with Breast & Lung Cancer – specialist to specialist consultation
- Launch with Hip & Knee Arthroplasty – GP to Specialist
EARLY QUALITY IMPROVEMENTS – SCN Projects

**Adult Coding & Triage System**
- Diagnostic coding of all surgical subspecialties across all hospitals in Alberta to determine in / out window waiting period for all Surgery
- All 5 Zones implementing – 3 waves of implementation – completed 15/16

**Stroke Action Plan**
- 15 smaller regional / rural sites in Alberta
- Implementing *Stroke Equivalent Care & Early Supported Discharge & Rehabilitation* protocols

**Adult Depression Pathway**
- RCT in Edmonton Zone Primary Care – 4 pronged approach to determine different levels of treatment options
- Spreading to Calgary Zone Primary Care networks in 14/15

[www.albertahealthservices.ca](http://www.albertahealthservices.ca)
Stroke Action Plan
Best Practice Use at 14 Primary Stroke Centres

Days

% use of order sets
% swallowing screen before oral intake
% pts with rehab assessment in 48h

Baseline
Q1 14/15
Q2 14/15
Q3 14/15
Q4 14/15
Q1 15/16
Stroke Action Plan
Length of Stay at 14 Primary Stroke Centres

Mean Acute LOS
Mean Overall LOS
Median Acute LOS
Median Overall LOS

Baseline
Q1 14/15
Q2 14/15
Q3 14/15
Q4 14/15
Q1 15/16
Stroke Action Plan
Patient Outcomes

Proportion with activity level improvement*
Proportion with impairment improvement *
Post-stroke complication rate (%)

Days

Proportion with activity level improvement*
Proportion with impairment improvement *
Post-stroke complication rate (%)

Baseline
Q1 14/15
Q2 14/15
Q3 14/15
Q4 14/15
Q1 15/16

*As measured by ≥ 1 point improvement in AusTOMs sub-score (5 Early Supported Discharge Program sites)
Accessibility

- Average wait for consult 59% faster than 2005
- Average wait for surgery 67% faster than 2005
- Faster access avoids $22.7M/yr out-of-pocket for patients (wages etc) + ~$2.5M system costs

Efficiency

- Surgical volume up 73% since 2004/05
- Inpatient bed use up only 5% since 2004/05
- 32,000 bed days gained since 2010 (a resource productivity gain of ~$32.8M)

Safety

- 30 day readmission rates down to 4% from 5% - so now avoiding ~$1M/year of inpatient costs
- Now a focus by provincial clinical committee on other safety improvements pending

www.albertahealthservices.ca
IMPROVEMENTS (2005-2013)
~20,000 patients now assessed for 9,600 surgeries per year

Acceptability
• 9 out of 10 patients highly satisfied
• 98% of patients like the team approach

Appropriateness
• 85% now mobilized day of surgery (up from 40% in 2009/10)

Effectiveness
• 85% have improved function
• Why 15% fail to improve is the subject of current prevention research
Results reported in 16 KPIs across all dimensions of quality

Recent additions:

- Blood transfusion
- Wait for surgery from ready-to-treat
- Derived benefit from surgery at 90 days

### Executive Summary

#### Table 1. Executive Summary

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary elective volume</td>
<td>N/A</td>
<td>124</td>
<td>130</td>
<td>129</td>
<td>131</td>
<td>Avg. per surgeon</td>
</tr>
<tr>
<td>Age (meanSD)</td>
<td>-</td>
<td>67.6</td>
<td>65.7 ±</td>
<td>67.4 ±</td>
<td>65.9 ±</td>
<td>65.9 ±</td>
</tr>
<tr>
<td>Female (%)</td>
<td>-</td>
<td>52.9</td>
<td>50.4</td>
<td>51.0</td>
<td>51.5 ±</td>
<td>51.5 ±</td>
</tr>
<tr>
<td>BMI (meanSD)</td>
<td>N/A</td>
<td>31.7 ±</td>
<td>31.0 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
</tr>
<tr>
<td>ASA 2,3 (%)</td>
<td>N/A</td>
<td>22.1</td>
<td>14.7</td>
<td>19.7</td>
<td>20.0 ±</td>
<td>20.0 ±</td>
</tr>
<tr>
<td>Pre-surgery VONAC PAIN (meanSD) (%)</td>
<td>N/A</td>
<td>31.6 ±</td>
<td>31.0 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
</tr>
<tr>
<td>TXSurgery EQOD PAIN moderate/severe PAIN (%)</td>
<td>N/A</td>
<td>31.6 ±</td>
<td>31.0 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
<td>31.9 ±</td>
</tr>
<tr>
<td>Access Wait for consult ≤ 8 wks (%)</td>
<td>N/A</td>
<td>5.0</td>
<td>6.7</td>
<td>5.0</td>
<td>5.0</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Access Wait for surgery ≤ 14 wks (%)</td>
<td>N/A</td>
<td>56.1</td>
<td>38.9</td>
<td>60.9</td>
<td>60.9 ±</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Eff. Total LOS ≤ benchmark (%)</td>
<td>-</td>
<td>55.0</td>
<td>60.0</td>
<td>51.7</td>
<td>51.0 ±</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Safety Readmit at 30 days (%)</td>
<td>N/A</td>
<td>2.4</td>
<td>2.5</td>
<td>2.4</td>
<td>2.5</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Safety Mechanical events (%)</td>
<td>N/A</td>
<td>1.6</td>
<td>0.7</td>
<td>1.6</td>
<td>1.0</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Safety Medical events (%)</td>
<td>N/A</td>
<td>1.6</td>
<td>1.4</td>
<td>0.9</td>
<td>2.5</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Effect WOMAC PAIN 3 months post (%)</td>
<td>N/A</td>
<td>75.05 ±</td>
<td>79.78 ±</td>
<td>78.09 ±</td>
<td>79.78 ±</td>
<td>79.78 ±</td>
</tr>
<tr>
<td>Effect EQOD PAIN 3 months post (%)</td>
<td>N/A</td>
<td>4.0</td>
<td>1.5</td>
<td>3.4</td>
<td>3.4</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Effect Report severe pain 3 months post (%)</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Accept Patients dissatisfied (%) (%)</td>
<td>N/A</td>
<td>3.7</td>
<td>2.3</td>
<td>1.1</td>
<td>1.6</td>
<td>Lower is better</td>
</tr>
</tbody>
</table>

"Your Performance" Legend:

- My results are above Alberta average
- My result is within Alberta average
- My result is below Alberta average

Confidential Continuous Improvement Reports for surgeons

[www.albertahealthservices.ca](http://www.albertahealthservices.ca)
IMPACTS

Over 6000 staff and clinicians Involved across 5 Zones & Partner Organizations

- Stroke Action Plan 14 sites
- Hip & Knee Plan – 12 sites
- Insulin Pump Program – 11 centers
- Vascular Risk Reduction
- Fragility & Stability – 12 Sites
- Appropriate Use of Antipsychotics
- Empathy – All Schools in Red Deer
- E-Referral – Lung / Hip & Knee
- Safe Surgery Checklist - 59 sites
- Enhanced Recovery After Surgery – 6 Sites

www.albertahealthservices.ca
SCN’s Further Value Adds to the System

• **Internal Experts and Consultants**
  – AACHT
  – CVH&S - Cardiac Surgery Wait Times
  – CVH&S - Expansion of Advanced Cardiac Services
  – MNCY – Value of Fetal Fibronectin
  – Province-wide Policies (Seniors, CC, ER, Surgery)

• **Innovation and Commercialization (with AIHS)**
  – Alberta SMEs and TEC Edmonton
  – MEDEC/SCN partnership discussions
  – RX&D/SCN partnership discussions
Partnership for Innovation & Research in the Health System

The Researcher

Users of Knowledge

On the same team creating value for money
Partnership for Research and Innovation in the Health System (PRIHS)

- **Partnership** between AIHS and AHS (equal $ contribution)

- Supports research and innovation aligned with SCNs that target *high impact activities* associated with any part of the continuum of care, with a particular emphasis on population health and community and primary care

- Demonstrate *evidence of value for money or improvements* within AHS

- Level of Funding: Up to a maximum of $250,000/year

- Term: Up to 3 years (with evidence of achievement), non-renewable
Snapshot of PRIHS / SCN Projects Partnership with AIHS

Partnerships for Research and Innovation in the Health System (PRIHS - 1)

Partnerships for Research and Innovation in the Health System (PRIHS - 2)

11 Grants Approved December, 2014

10 Grants - Underway

www.albertainnovates.ca/funding
Challenges

• Initial lack of recognition within AHS
• Role clarity (operations vs strategy) especially within operational type networks (Surgery, Emergency and Critical Care)
• Priority overload
• Frontline (Network) vs Operational Priorities
• Resources allocation to network to achieve mandate
Questions?